MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04697

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1002 Woodyear Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES BALL

3.(b) Social Security Number: 220-05-3386

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 2, 1918

8. AGE: Years: 27 Months: 8 Days: 23 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Eli Ball
13. Birthplace: Richmond County, Va.

MOTHER 14. Maiden name: Kate Rich
15. Birthplace: Richmond County, Va.

16. Informant: Mrs. Kate Ball (Mother)
Address: 518 Pearl St., Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 28 - 46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn.
Location:

18. Funeral director: Thomas F. Kelson
Address: 1303 Pressman St.

19. July 25, 1946 (Date rec'd by registrar) Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 1946 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1946 to May 25, 1946 and that I last saw him alive on May 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1938
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-25-46

VS A15 5-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore (45-2)

04698

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Louisville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Bitzel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George R. Bitzel
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 26, 1883

8. AGE: Years	Months	Days	If less than one day
62	9	6	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Charles H. Conaway
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Schaefer
15. Birthplace: Maryland

16. Informant: George R. Bitzel
Address: Louisville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/5/46 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cemetery
Location: Smallwood, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. May 3 1946 (Date rec'd by registrar) C. Harry Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1946, at 1.15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945, to May 2 1946
and that I last saw her alive on May 2 1946

	DURATION
Immediate cause of death: Carcinoma mouth (Rt. upper gum) & metastases & cachexia	1 yr.
Due to: Secondary anemia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma mouth
Date of op. May 18/1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wglenn Speicher M. D. or other
Address: Westminster, Md. Date signed 5/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★4699

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1411 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
BERNIECE BLACK

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1926

8. AGE:	Years	Months	Days	If less than one day
	19	11	26	hrs. min.

9. Birthplace New Windsor, Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Clayton Black
13. Birthplace Unknown
MOTHER 14. Maiden name Ella Fishel
15. Birthplace Unknown
16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22-1946 (month) (day) (year)
Cemetery or crematory Mt. Olive Cemetery
Location Frederick County Md
18. Funeral director W. W. Hartley & Sons
Address Union Bridge & New Windsor Md
19. May 20, 19 46 (Date rec'd by registrar) Albert E. Lowenbach Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 19 46 at 3:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 19 46 to May 20, 19 46 and that I last saw h...er alive on May 20, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Leman, M. D.
M. D. or other
Address Henryton, Md. Date signed 5-20-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04780

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 164 East Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pearl Blubaugh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 28 1908

8. AGE: Years	Months	Days	If less than one day
37	7	11	hrs. min.

9. Birthplace: Allegany County, Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER

12. Name: Delemar Dayton

13. Birthplace: Allegany County, Maryland

MOTHER

14. Maiden name: Mary Blubaugh

15. Birthplace: Allegany County, Maryland

16. Informant: Records of Springfield State Hosp.

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/12/46 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.,

18. Funeral director: Jacob Faber

Address: Frostburg Md.

19. May 9 1946 (Date received by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1946, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1946, to May 9 1946 and that I last saw her alive on May 9, 1946

Immediate cause of death	DURATION
Pulmonary tuberculosis	1½ (?)
Due to:	
Due to:	
Other conditions: Deaf Mute, Psychosis with mental deficiency	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. M. D. or other

Address: Sykesville, Md. Date signed: 5-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A35

04701

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Frederick
City or town: Frederick
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 132 W. All Saint Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES ANDREW BOWIE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 13, 1869

8. AGE:

Years	Months	Days	If less than one day
77	1	20	hrs. min.

9. Birthplace: Centerville, Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: James A. Bowie, Sr.
13. Birthplace: Centerville, Md.
MOTHER 14. Maiden name: Harriett (?)
15. Birthplace: Centerville, Md.
16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6-1946 (month) (day) (year)
Cemetery or crematory: Centerville Md
Location: Frederick Co Md
18. Funeral director: Rob W Barber
Address: Thurmont Md

19. 5/3 (Date rec'd by registrar) 19 46 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 19 46, at 8.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 19 46 to May 3, 19 46 and that I last saw him alive on May 3, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George D Adams MD M. D. or other
Address: Henryton, Md. Date signed 5/3/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (135-2)

CERTIFICATE OF DEATH

04702

Reg. Dist. No. 14

P

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yr. no mo. 8 days.
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yr. 0 mo. 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1723 Regester Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harold Cardwell (HAROLD HOWELL CARDWELL)

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	24	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Streetcar motorman
11. Industry or business: BALTIMORE TRANSIT COMPANY

FATHER
12. Name: George Cardwell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Martha Ellen Hilliard
15. Birthplace: Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/46 (month) (day) (year)
Cemetery or crematory: Meadow Ridge Cemetery
Location: ELKRIDGE, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 5-9 1946 (Date rec'd by registrar) Ava Hechmiller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1946, at 12:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11 1943, to May 7 1946
and that I last saw him alive on May 7 1946

Immediate cause of death	DURATION
Accidental mechanical suffocation, strangled on food	instant.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	14 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D. Robert Bertrand May, M.D.
Springfield State Hospital M. D., or other
Address: Sykesville, Maryland Date signed: 5-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32-0

CERTIFICATE OF DEATH

04703

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 711 Druid Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: REGINA CARROLL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 14, 1922

8. AGE:

Years	Months	Days	If less than one day
23	11	17	hrs. min.

9. Birthplace: Howard County, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Ernest Carroll
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Robinson
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/46 (month) (day) (year)

Cemetery or crematory: Asbury Cem

Location: Asbury, Md.

18. Funeral director: Kate R. Williams

Address: 822 N. Schroeder St.

19. 5/1 (Date rec'd by registrar) 1946 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1946, at 12.00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Noon April 10, 1946, to May 1, 1946 and that I last saw h er alive on May 1, 1946

Immediate cause of death	DURATION
Acute Miliary Tuberculosis	1 month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George R Adams MD
M. D. or other

Address: Henryton, Md. Date signed: 5/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04704 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 10 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1236 St. Matthew Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ELLA FIELDS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 17, 1890

8. AGE: Years	Months	Days	If less than one day
56	2	5	hrs. min.

9. Birthplace: Weldon, N.C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William Hill
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Betty Tilery
15. Birthplace: North Carolina

16. Informant: Patient
Address

17. Shipper (Burial, cremation, or removal. Which?) Date thereof 5-24-46 (month) (day) (year)
Cemetery or crematory: Enfield cem.
Location: Enfield N. C.
18. Funeral director: Byrum & Mamie Wright
Address: 721 Aisquith St. Balto., Md.
19. May 22, 1946 (Date rec'd by registrar) Albert R. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22, 1946, at 11:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945 to May 22, 1946 and that I last saw her alive on May 22, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 25, 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 5-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (80)

04705

CERTIFICATE OF DEATH

Reg. Diat. No. 7X

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo 21 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 8 mo 21 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 South Calhoun St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Agnes Gemmill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12/14/1915

8. AGE: Years	Months	Days	If less than one day
30	4	28	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Dependent
11. Industry or business:
FATHER 12. Name: Robert Gemmill
13. Birthplace: Baltimore
MOTHER 14. Maiden name: Francis Shaad
15. Birthplace: Germany
16. Informant: Robert Gemmill
Address: 23 South Calhoun St Balto
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 1946 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto Md
18. Funeral director: Roth & B. M. Walton
Address: Pratt & Stricker Sts Balto Md
19. 5-14 1946 (Date rec'd by registrar) Amy Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 1946, at 6-20 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21st 1946, to May 12th 1946
and that I last saw h[illegible] alive on May 12th 1946

Immediate cause of death	DURATION
(a) Encephalitis	2 yrs
Due to	
Due to Epilepsy	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Gaston M.D. M. D. or other
Address: Sykesville Md Date signed 5-12-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 04796 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County Carroll
City or town Rural Manchester Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 78 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Henry Graf

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Laura Graf
6.(c) If alive, give age 74 years

7. Birth data of deceased (mo., day, yr.) April 6 1868

8. AGE: Years 78 | Months 1 | Days 23 | If less than one day hrs. min.

9. Birthplace Maryland Carroll Co.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
12. Name John L Graf
13. Birthplace Germany
MOTHER
14. Maiden name Anna E Stried
15. Birthplace Germany

16. Informant Laura Graf
Address Manchester Md

17. Burial Date thereof 6-1-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location Manchester Md

18. Funeral director Jacob Winks Sons
Address Manchester Md

19. June 2 1946 Mrs W.P.S. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1946 to May 29 1946
and that I last saw him alive on May 28 1946

Immediate cause of death Coronary Sclerosis — DURATION 9 yrs.
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operation —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE W. C. Porterfield M. D. or other
Address Hampstead Md Date signed 5/31/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

04707

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 17 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3301 Paton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ROBERT EDWARD HARRIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Lillian Harris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 18, 1904

8. AGE:	Years	Months	Days	If less than one day
	42	0	7	..... hrs. ..... min.

9. Birthplace: Warrenton, Va.
(Town, county, and state)
10. Usual occupation: Race Horse Groom
11. Industry or business

FATHER
12. Name: Edward Harris
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Hubbard
15. Birthplace: Virginia

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28, 1946 (month) (day) (year)
Cemetery or crematory St. Luke's Cem.
Location Lyksville, Md.
18. Funeral director C. Harry Meier
Address Lyksville, Md.
19. May 25, 1946 (Date rec'd by registrar) Albert R. Shoemaker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1946, at 3:40A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8, 1946, to May 25, 1946 and that I last saw him alive on May 25, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 5-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-5

CERTIFICATE OF DEATH

Reg. Dist. No. 04708 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 8 mo., 21 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 402 East 23rd. Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALICE HILLIARD

3.(b) Social Security Number: 217-20-7025

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 6, 1910

8. AGE: Years	Months	Days	If less than one day
35	10	25	hrs. min.

9. Birthplace: Fremont, N.C. (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business:
FATHER 12. Name: Gray Spate
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Anna Hilliard
15. Birthplace: North Carolina
16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6-1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:
18. Funeral director: Robert E. Williams
Address: 1515 McElderry St Balto Md

19. May 2, 1946 (Date rec'd by registrar) Robert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2, 1946 at 8:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1944 to May 2, 1946 and that I last saw her alive on May 2, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Geo. H. Adams M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-2-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 151-d

CERTIFICATE OF DEATH

04709 76

Reg. Dist. No. (144)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Frizzelsburg - rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Frizzelsburg - rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Janice Elizabeth Stumerick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): September 16, 1945

8. AGE: Years	Months	Days	If less than one day
	8	5	hrs. min.

9. Birthplace: Emmitsburg, Frederick Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Leroy Stumerick
13. Birthplace: Thurmont, Md

MOTHER
14. Maiden name: Lena Eyler
15. Birthplace: Thurmont, Md.

16. Informant: Leroy Stumerick
Address: Frizzelsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22 1946 (month) (day) (year)

Cemetery or crematory: United Brethren

Location: Thurmont, Md.

18. Funeral director: M. L. Creager & Son

Address: Thurmont, Md.

19. 5/22/46 (Date rec'd by registrar) 19 Blanche L. Eyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1946, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1945 to May 21 1946 and that I last saw her alive on May 20 1946

	DURATION
Immediate cause of death: cerebral convulsions	4 months
Due to: congenital microencephaly since birth	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. R. Cook M.D. M. D. or other

Address: Emmitsburg, Md. Date signed 5-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04710

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: LaPlata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOSEPH JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown 1918

8. AGE: Years: 28 | Months: ? | Days: ? | If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles County, Md.
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER
12. Name: John Johnson
13. Birthplace: LaPlata, Md.

MOTHER
14. Maiden name: Susie Briscoe
15. Birthplace: Bryantown, Md.

16. Informant: John Johnson (Father)
Address: LaPlata, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5/10/46 (month) (day) (year)
Cemetery or crematory: Locust Neck Cemetery
Location: La Plata, Md
18. Funeral director: Hunt & Ryan
Address: Waldorf, Md.

19. 5/7 (Date rec'd by registrar) 19 46 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 19 46 at 9.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 19 46 to May 7, 19 46 and that I last saw him alive on May 7, 19 46

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb (?) 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M. D.
M. D. or other
Address: Henryton, Md Date signed 5/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

0471 (176)

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Finksburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Finksburg Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. Gamber (If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Thomas R Jones

3.(b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Maggie F Jones

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) June 21 - 1883

8. AGE: Years 62 Months 10 Days 29 If less than one day ... hrs. ... min.

9. Birthplace Baltimore Co Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name James Jones

13. Birthplace Maryland

MOTHER 14. Maiden name Rebecca Fitzell

15. Birthplace Maryland

16. Informant Mr Maggie F Jones

Address Finksburg Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 - 1946 (month) (day) (year)

Cemetery or crematory Beaver Dam Cemetery

Location Union Bridge Md

18. Funeral director D. D. Hartzler & Sons

Address Union Bridge & New Windsor Md

19. May 22, 1946 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1946, at 5.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-44 19 , to 5/20/46 19 , and that I last saw h im alive on 5/20/46 19

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to Arteriosclerosis

Other conditions

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury injured at work?

23. SIGNATURE James G. Saffell M. D. or other

Address Reisterstown Md Date signed 5/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

04712

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Rural-Taneytown
(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural-Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Ida Brubaker Koontz

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Thomas Koontz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 22, 1861

8. AGE: Years	Months	Days	If less than one day
84	6	10	..... hrs. ..... min.

9. Birthplace: Taneytown, Carroll County, Md.
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER
12. Name: William Brubaker
13. Birthplace: Penna.

MOTHER
14. Maiden name: Sarah Kepner
15. Birthplace: Penna.

16. Informant: William B. Koontz
Address: Nr. Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1946 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. May 5, 1946 (Date received by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1946, at 2:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946, to May 2 1946, and that I last saw h[illegible] alive on May 2 1946

Immediate cause of death: Arterio Sclerosis — DURATION

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J N Legg M. D. or other

Address: Union Bridge Date signed: 5-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04713

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll Co.
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Pool Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pool Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Albert Robert Lawrence

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Salome Lewis Lawrence
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 16, 1871

8. AGE: Years	Months	Days	If less than one day
74	11	13	____ hrs. ____ min.

9. Birthplace St. Lawrence Co. New York (DeKalb) (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Henry Lawrence
FATHER 13. Birthplace New York State
MOTHER 14. Maiden name Nancy Thompson
MOTHER 15. Birthplace Ireland
16. Informant Mrs. David E. Lawrence
Address Westminster, Md. R.D. Pool Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1 '46 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster, Md.
18. Funeral director J. E. Myers, Jr.
Address Westminster, Md.
19. 5/31/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1946 at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1942 to May 29 1946 and that I last saw him alive on May 29, 1946

Immediate cause of death	DURATION
Valvular heart disease	3 to yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____
Autopsy results ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE C. Reese Wilbern M. D. or other
Address Westminster Date signed 5/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17a)

CERTIFICATE OF DEATH

04714

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 1 mo., 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium, Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 404 Worsely Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edgar Morris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 30, 1938

8. AGE: Years: 7 | Months: 8 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: child
11. Industry or business

FATHER
12. Name: John Morris
13. Birthplace: Gloucester County, Va.

MOTHER
14. Maiden name: Ora Garland
15. Birthplace: Gloucester County, Va.

16. Informant: Ora Morris (Mother)
Address: 404 Worsley St., Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. A. County
18. Funeral director: Laymen S. Sanders
Address: 1412 E. Preston Street

19. May 3, 1946 (Date rec'd by registrar) Albert R. Sanderlin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1946, at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1944, to May 3, 1946 and that I last saw him alive on May 3, 1946

Immediate cause of death	DURATION
Multiple Tuberculous Osteomyelitis.	7 mo.
Due to:	
Due to:	
Other conditions: Tuberculous Cervical Adenitis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George S. Adams MD M. D. or ~~other~~
Address: Henryton, Md. Date signed: 5-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04715

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

1.(a) FULL NAME: Marshall William Nelson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 6, 1907

8. AGE: Years 38 | Months 10 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Bar Tender

11. Industry or business Tavern

FATHER 12. Name Harry N. Nelson

13. Birthplace Md.

MOTHER 14. Maiden name Etta Collins

15. Birthplace Md.

16. Informant Etta Nelson

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1946 (month) (day) (year)

Cemetery or crematory Johnsville Cemetery

Location Johnsville, Carroll Co, Md.

18. Funeral director C. Harry Uhler

Address Sykesville, Md.

19. May 7 1946 (Date rec'd by registrar) C. Harry Uhler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1946 at 12-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946 to May 6 1946

and that I last saw him alive on May 6 1946

Immediate cause of death	DURATION
Valvular Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H A Bamm MD

M. D. or other

Address Sykesville Md Date signed 5/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04716

Reg. Diat. No. 7483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural- Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural- Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Gaither Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clausina M. Olbrecht

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: Charles F. Olbrecht
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 6, 1873

8. AGE: Years	Months	Days	If less than one day
73	3	24	hrs. min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: George Schroeder
13. Birthplace: Germany
MOTHER 14. Maiden name: Louisa Volkendt
15. Birthplace: Germany
16. Informant: Mrs. Carolyn Anderson
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-3-46 (mouth) (day) (year)
Cemetery or crematory: Springfield Cemetery
Location: Sykesville, Md.
19. Funeral director: C. Harry Weer
Address: Sykesville, Md.
19. May 31 1946 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1946 at 6:21 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Cardiac Decompensation	
Due to Arteriosclerotic Cardio-Vascular Lesion	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner
M. D. or other
Address: Westminster, Md. Date signed: May 30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

CERTIFICATE OF DEATH

04717

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs. 8 mo. 4 da.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 10 yrs. 8 mo. 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1128 Riverside Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: NETTIE PENN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George Penn

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): February 1, 1893

8. AGE: Years	Months	Days	If less than one day
53	3	7	..... hrs. ..... min.

8. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Harry Wehnert
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mollie Furley
15. Birthplace: West Virginia

18. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1946 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Derr

Address: Sykesville, Md.

19. May 13 1946 (Date rec'd by registrar) C. Harry Derr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1946, at 7.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9 1935, to May 8 1946

and that I last saw her alive on May 8 1946

Immediate cause of death	DURATION
Syphilitic Meningo-encephalitis	12 yrs.
Due to	
Due to	
Other conditions: Psychosis with syphilitic meningo-encephalitis (Include pregnancy within 3 months of death)	12 yrs

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Maud M. Rees M. D. or other

Address: Sykesville Md Date signed: 5-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04718

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Turners Station
(If outside city or town limits, write RURAL and give nearest town)
Street No. 213 Chestnut Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY PRIDGEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 21, 1897

8. AGE:

Years	Months	Days	If less than one day
48	4	15	hrs. min.

9. Birthplace: Rocky Mount, N.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

MOTHER
12. Name: Sophia West
15. Birthplace: Unknown

FATHER
12. Name: Ballas Pridgen
13. Birthplace: North Carolina

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. A. County
18. Funeral director: Laymen Saunders
Address: 1412 E. Preston Street

19. May 6, 1946 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1946, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946, to May 6, 1946 and that I last saw him alive on May 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

04719

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Taylorsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LEANNAH Reaver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George F. Reaver deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 20, 1862

8. AGE:

Years	Months	Days	If less than one day
83	10	12	..... hrs. ..... min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John Long
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Condon
15. Birthplace: Maryland

16. Informant: Miss Bertha Reaver
Address: Westminster, Md.

17. Burial
(Burial, ~~cremation, or removal. Which?~~)
Date thereof 5-6-46 (month) (day) (year)
Cemetery or ~~crematory~~: Bethany
Location: Franklinville, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. May 4 1946
(Date received by registrar)
E. McFarland
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1946, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1946, to May 2 1946
and that I last saw her alive on May 2 1946

Immediate cause of death	DURATION
Myocardial degeneration	2+ months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. Reese Wilkens M. D. ~~or Coroner~~
Address: Westminster Date signed 5/3/46

04720

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R6-a)

CERTIFICATE OF DEATH

82

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 712 W. Hamburg St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK REESE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Kate C. Reese

deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1863

8. AGE: Years	Months	Days	If less than one day
83	4	16	hrs. min.

9. Birthplace: Baltimore City, Md.
(Town, county, and state)

10. Usual occupation: Cigar Maker (retired)

11. Industry or business:

FATHER
12. Name: Peter Reese
13. Birthplace: Germany

MOTHER
14. Maiden name: Not Known
15. Birthplace:

16. Informant: Mrs. T. M. Lowman

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 5-19-46 (month) (day) (year)

Cemetery ~~or crematory~~: Prospect

Location: nr. Mt.Airy, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. May 18 1946 Wm D Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1946 to May 17 1946 and that last saw h~~im~~ alive on May 16 1946

Immediate cause of death	DURATION
Hypostatic Pneumonia	
Due to Accidental fall on pavement Cus. Fracture of R. Hip.	apx 10
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of April 11th 1946

Where did injury occur? 712 West Hamburg Street (City or town) Baltimore (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Public place

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: C M Van Sickle M. D. or other

Address: Mt Airy Md Date signed: 5/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No. I 0 4 MAY 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04721

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegheny
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Johanna Schmidt

3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Frank Schmidt
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov 28 - 1868

8. AGE: Years: 77 67 | Months: 5 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Edward Grohmann
13. Birthplace: Germany

MOTHER
14. Maiden name: Johanna "
15. Birthplace: Germany

16. Informant: Mrs William M. Kennedy
Address: La Vale, Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May - 9 - 1946 (month) (day) (year)
Cemetery or crematory: Woodland
Location: Newark New Jersey

18. Funeral director: J. F. Pelse
Address: Westminster - Maryland

19. May 4 1946 (Date rec'd by registrar) C. Hood Dees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th 1946, at 3-10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1943, to May 4th 1946, and that I last saw h.er alive on May 4th 1946

	DURATION
Immediate cause of death: Chronic Myocarditis	3 yrs
Due to:	
Due to: Cerebral Arterio Sclerosis ?	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other
Address: Sykesville Md. Date signed: 5/4/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

04722

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: CARROLL
City or town: SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 8 mos. 23 days.
Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL
How long in hospital or institution? 4yrs. 8 mos. 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: FREDERICK
City or town: BRUNSWICK
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Not known
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: HERBERT NELSON SELBY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 8, 1913.

8. AGE: Years	Months	Days	If less than one day
32	6	23	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Not known
FATHER 12. Name: DAVID SELBY
13. Birthplace: BRUNSWICK, MARYLAND.
MOTHER 14. Maiden name: LULU BAILEY
15. Birthplace: LURAY, VIRGINIA
16. Informant: HOSPITAL RECORDS
Address: SPRINGFIELD STATE HOSPITAL
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2 1946 (month) (day) (year)
Cemetery or crematory: Reformed
Location: Brunswick Md.
18. Funeral director: C. H. Zeltz & Bro
Address: Brunswick Md.
19. May 31 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31, 1946. 19..... at 4.00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8 1941, to May 31 1946 and that I last saw him alive on May 31 1946

Immediate cause of death: Cardiac failure — DURATION: Immediate
Due to: syphilis — For Life
Due to: .....
Other conditions: Syphilitic meningo-encephalitis, juvenile paresis — For Life
(Include pregnancy within 3 months of death)
Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Allan Burke, M.D.
Springfield State Hospital M. D. or other
Address ..... Date signed 5-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-C

CERTIFICATE OF DEATH

BC 04723

Reg. Diat. No. 74

1. PLACE OF DEATH

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs 2 days

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 516 S Bond

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Katherine Kalinouske Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4th 1910

8. AGE:

Years	Months	Days	If less than one day
36	2	24	hrs. min.

9. Birthplace: Chicago Ill

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER — 12. Name: Joseph Kalinouske

13. Birthplace: Poland

MOTHER — 14. Maiden name: Frances Rybaccjewska

15. Birthplace: Poland

16. Informant: Mrs Frances Kalinouski

Address: 516 S Bond St. Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5 - 31 - 46 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cem

Location: Balto County

18. Funeral director: John M. Weber

Address: 401 S. Chester Street

19. 1-29 1946 (Date rec'd by registrar) Applebaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28th 1946, at 7-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7th 1929 to May 28th 1946 and that I last saw h alive on May 28th 1946

Immediate cause of death	DURATION
Chronic Hypertension	5 yrs
Due to: Cystic Kidney	2 Days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. D. Gaston M.D. M. D. or other

Address: Sykesville Md. Date signed: 5/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-0)

04724

CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos 1 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 mos 1 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Laura Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19th 1908

8. AGE: Years: 38 Months: 1 mo Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

MOTHER FATHER

12. Name: Robert J. Smith

13. Birthplace: Maryland

MOTHER

14. Maiden name: Julia A. Foster

15. Birthplace: Maryland

16. Informant: Mrs. Violet Hershelberger

Address: 533 Second St Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-22-46 (month) (day) (year)

Cemetery or crematory: Annapolis

Location: Annapolis, Md.

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. May 19 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19th 1946, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17th 1946 to May 19th 1946 and that I last saw h.. alive on May 19th 1946

Immediate cause of death	DURATION
Terminal Pneumonia	4 hrs
Due to: Fracture due to: Falling to floor, while fighting with another patient. Cir. O.D.	
Due to: Epilepsy	37 yrs
Other condition: Fracture of left femur	9 da

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: May 13th, 1946.

Where did injury occur? Springfield State Hospital, Sykesville, Maryland. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Disturbed Cottage, No. 2.

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: W. H. Martin M.D. M. D. or other

Address: Sykesville, Md. Date signed: 5/19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04725 Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs 6 mo.
Hospital, institution, or street address where death occurred: Railroad ave.
How long in hospital or institution? 4 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md. Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. Snydersburg (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Florence Leora Snyder

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: George R. Snyder.
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): February 19 1892.
8. AGE: Years: 54 Months: 2 Days: 13 If less than one day: ...hrs. ...min.
9. Birthplace: Manchester Maryland (Town, county, and state)
10. Usual occupation: House wife.
11. Industry or business: Home

FATHER
12. Name: Edward J. Wise
13. Birthplace: Maryland

MOTHER
14. Maiden name: Lizzie Cosker
15. Birthplace: Maryland

16. Informant: George R. Snyder. Address: Hampstead Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5-1946 (month) (day) (year)
Cemetery or crematory: Snydersburg
Location: Carroll Co Md
18. Funeral director: Edw A Tipton
Address: Hampstead Md
19. May 3 1946 (Date rec'd by registrar) J. Lewis Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2. 1946, at 3:15 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 13 1943, to May 2 1946
and that I last saw h.e.r. alive on May 1 1946
Immediate cause of death: Generalized Carcinomatosis — DURATION: 3 yrs
Due to: Primary Carcinoma Breast — 5
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of Breast & Metastasis. Date of op. 10-28-43
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Paul E. Bush M.D. M. D. or other
Address: Hampstead Md. Date signed: 5-2-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 04726

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 2 mos 7 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 2 mos 7 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: 4002 Glenmore Ave (If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore Md. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ruby Jane Snyder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Martin Snyder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 16th 1887

8. AGE: Years 58 | Months 9 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Pennsylvania (Town, county and state)

10. Usual occupation: housework.

11. Industry or business: at home

MOTHER FATHER

12. Name: Archibald Stewart

13. Birthplace: Penna

MOTHER

14. Maiden name: Josephine Forman.

15. Birthplace: Penna

16. Informant: Martin J Snyder

Address: 2 Glenmore Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-23-46 (month) (day) (year)

Cemetery or crematory: Parkwood Mem.

Location: Balto. Md.

18. Funeral director: Leonard J. Reich

Address: 5305 Harford Rd.

19. May 22 1946 C. Harry Weer Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21st 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17th 1943 to May 21st 1946 and that I last saw her alive on May 21st 1946

Immediate cause of death	DURATION
Coronary Occlusion	
with Myocarditis	2 da.
Due to Puerperal	
Chronic Myocarditis	3 yrs
Due to Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Coronary Occlusion Chr. Myocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. J. Martin M.D. M. D. or other

Address: Sykesville Md. Date signed: 5/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Items 13 and 15 changed by statement of funeral director in person 10-3-46 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

04727

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Penelope V Staunbury

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Whitfield Staunbury
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 3-1846

8. AGE:

Years	Months	Days	If less than one day
99	6	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Jacob Algire
13. Birthplace: Md Co, Maryland

MOTHER
14. Maiden name: Sarah Christ
15. Birthplace: Maryland YORK SPRINGS, Pennsylvania

16. Informant: Mrs Walter Reed
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26/46 (month) (day) (year)
Cemetery or crematory: Hampstead
Location: Hampstead Md
18. Funeral director: Edw S Tipton
Address: Hampstead Md

19. May 26 1946 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1946 at 3:05 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 43 to May 25 1946 and that I last saw her alive on May 25 1946

	DURATION
Immediate cause of death: Congestive Heart Failure	3 mins
Due to: Arterio-Sclerosis	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Cartinhour M. D. or other
Address: Hampstead Md Date signed 5/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

★ 04728

Reg. Dist. No. 16

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Cassell Home
How long in hospital or institution? 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma C. Stoner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife: Samuel C. Stoner
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19, 1869

8. AGE:

Years	Months	Days	If less than one day
77	1	12	hrs. min.

9. Birthplace: Carroll County, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Daniel Snyder
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine Leister
15. Birthplace: Maryland

16. Informant: Mrs. J. H. Allender
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/3/46 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster, Md.

18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/1 (Date rec'd by registrar) 1946 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1946, at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946 to May 1, 1946 and that I last saw her alive on April 30, 1946

Immediate cause of death	DURATION
Myocardial degeneration	2+ years
Due to Arteriosclerosis	15+ yrs
Due to	
Other conditions Hemiplegia	10+ years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E Reese Wilbern M. D. or other
Address: Westminster Md. Date signed: May 1, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04729 Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs 10 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 14 yrs 10 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: 946 N Chester St

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore Md

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Suchanek

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23 - 1912

8. AGE: Years 33 | Months 9 | Days 18 | If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: Edward Suchanek

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Amelia Doyle

15. Birthplace: Baltimore

16. Informant: Edward Suchanek

Address: 946 N Chester St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-15-46 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Baltimore Md

18. Funeral director: George N. Leimbach

Address: 525 Lyndhurst St.

19. May 12 19 46 (Date rec'd by registrar) C. Harry Weese Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12th 19 46 at 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11th 19 32 to May 12 19 46

and that I last saw h[illegible] alive on May 12th 19 46

Immediate cause of death	DURATION
Coronary Occlusion	1 hr
Due to:	
Due to: Epilepsy with Psychosis	27 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. J. Gaston M.D. M. D. or other

Address: Sykesville Date signed: 5/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

*04730 Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Malinda C Swanson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Theodore Swanson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1868

8. AGE:

Years	Months	Days	If less than one day
77	8	26	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Nurse
11. Industry or business

FATHER
12. Name Levi Fauer
13. Birthplace Maryland

MOTHER
14. Maiden name Mary A Bonar
15. Birthplace Maryland

16. Informant Mrs Irade Boring
Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7/46 (month) (day) (year)
Cemetery or crematory Shamans Church
Location York Co. Penna
18. Funeral director Edw C Hilton
Address Hampstead Md
19. May 6 1946 John S. Hafer Jr. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May, 4 1946, at 10:00 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1945, to May, 4 1946 and that I last saw her alive on May, 4 1946

	DURATION
Immediate cause of death Congestive Heart Failure	3 mo.
Due to Hypertensive Cardio-Vascular disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. C. Porterfield M. D. or other
Address Hampstead Md Date signed 5-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore (83-B)

CERTIFICATE OF DEATH

★ 04731 Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yr. 3 mo., 13 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 yr., 3 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 754 McHenry Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Beamer Toner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	6	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and atate)
10. Usual occupation: Cold storage dept. mgr.
11. Industry or business: Furrier

FATHER
12. Name: Joshua Toner
13. Birthplace:

MOTHER
14. Maiden name: Bertha MacFrederick
15. Birthplace: West Virginia

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-46 (month) (day) (year)
Cemetery or crematory: London Park Cem.
Location: Balto. Md.
18. Funeral director: John O. Mitchell & Son
Address: 1900 Eutaw Place

19. May 16 1946 (Date rec'd by registrar) C. Harry Elsner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1946, at 7:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to May 16 1946 and that I last saw him alive on May 16 1946

	DURATION
Immediate cause of death: Cerebral thrombosis	30 min.
Due to:	
Due to:	
Other conditions: Psychoneurosis, neurasthenic type	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or Other
Address: Sykesville, Maryland Date signed: 5-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

04732

CERTIFICATE OF DEATH

★ Reg. Dist. No. 7#83

1. PLACE OF DEATH:
County Carroll
City or town Day
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Day
(If outside city or town limits, write RURAL and give nearest town)
Street No. Woodbine P. O.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Grace Agnes Wetzel

3.(b) Social Security Number

4. Sex: F.
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Marshall Wetzel
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 23, 1871
8. AGE: Years 75 Months 4 Days 26 If less than one day ..... hrs. ..... min.
9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: George Murray
13. Birthplace: Md.
MOTHER 14. Maiden name: Bridget Gleeman
15. Birthplace: Md.
16. Informant: Mr. Marshall Wetzel
Address: Woodbine, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26, 1946 (month) (day) (year)
Cemetery or crematory: Brandenburg Cem.
Location: Berrett, Carroll Co., Md.
18. Funeral director: C. Harry Wees
Address: Sykesville, Md.
19. May 25 1946 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1946 at 5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to May 23 1946
and that I last saw her alive on May 22 1946

	DURATION
Immediate cause of death: Clin. Cardiac decompensation	3 mo
Due to: Chr. Myocarditis	?
Due to:	
Other conditions: Hypertrophic Arthritis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Stanley Grabill M. D. or other
Address Woodbine, Md. Date signed 4/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04733

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 19 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 613 W. Preston Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HOWARD ROOSEVELT WILKERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1913

8. AGE: Years	Months	Days	If less than one day
32	8.	16	hrs. min.

9. Birthplace: Saxes, Va. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business:

FATHER
12. Name: Henry Wilkerson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Louisa Opey
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 30 46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: A. A. County
18. Funeral director: Mrs. R. A. Elliott & Daughter
Address: 1129 N. Caroline St.

19. May 27, 1946 (Date rec'd by registrar) Albert R. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1946, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1946 to May 27, 1946 and that I last saw him alive on May 27, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 16, 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D. M. D. or other
Address: Henryton, Md. Date signed: 5-27-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04734

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211 N. Durham St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MABEL WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1921

8. AGE:

Years	Months	Days	If less than one day
24	10	5	hrs. min.

9. Birthplace: Darlington, S.C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Robert Young
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Marilyn Williams
15. Birthplace: Darlington, S.C.

16. Informant: Patient
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1946 (month) (day) (year)
Cemetery or crematory: Winston Salem
Location: North Carolina
18. Funeral director: Elroy O. Wilson
Address: 1000 Beantley ave

19. May 29, 1946 (Date rec'd by registrar) Albert A. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29, 1946, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16, 1946, to May 29, 1946 and that I last saw h er alive on May 29, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1939
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 5-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04735

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr. 1 mo. 27 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 yr. 1 mo. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 North Front Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
William Edward Winkler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Rosetta Bowers Winkler (Deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 14, 1861

8. AGE: Years	Months	Days	If less than one day
85	4	6	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business

FATHER
12. Name Thomas Winkler
13. Birthplace Prince George Co., Md.

MOTHER
14. Maiden name Caroline ?
15. Birthplace Prince George Co., Md.

16. Informant Springfield State Hosp. records
Address Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-46 (month) (day) (year)
Cemetery or crematory Springfield State Hosp. Cem.
Location Sykesville, Md.
18. Funeral director C. Harry Ebert
Address Sykesville, Md.

19. May 21 1946 (Date rec'd by registrar) C. Harry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1946, 9:45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1944 to May 20 1946 and that I last saw him alive on May 20 1946

Immediate cause of death Carcinoma of bladder — DURATION 1 year

Due to Arteriosclerotic heart disease, prior to 1944

Due to Hydronephrosis secondary to carcinoma of bladder

Other conditions Perforating peptic ulcer

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results See causes of death above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.
Springfield State Hospital M.D. or other
Address Sykesville, Maryland Date signed 5-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75d)

CERTIFICATE OF DEATH

04736

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. Manchester Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ann Yingling

3.(b) Social Security Number None

4. Sex F.

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Charles M. Yingling

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Dec. 9 - 1868

8. AGE: Years 77 Months 4 Days 28 If less than one day ....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jesse Wright

13. Birthplace Md.

MOTHER 14. Maiden name Annie Wagner

15. Birthplace Md.

16. Informant Charles J. Yingling

Address Westminster Md. R.D. #4

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 - 1946 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster, Md.

18. Funeral director H Bankard Son

Address Westminster, Md.

19. 5/9 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1946, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1946, to May 7 1946

and that I last saw her alive on May 6 1946

	DURATION
Immediate cause of death Cerebral Hemorrhage	2 da
Due to Arteriosclerosis	
Due to Hypertension & Myocardial degeneration	Several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glen Speicher M.D. or other

Address Westminster Date signed 5/7/46